		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0042549

Facility Name: RIVER PARK HEALTHCARE CENTER

Address: 2545 24th ST (Number) ROCK ISLAND (City) 61201 (Zip Code)

County: ROCK ISLAND

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4127168

Date of Initial License for Current Owners: 03/06/97

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	177	Skilled (SNF)	177	64,605	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	177	TOTALS	177	64,605	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,845		6,320	8,165	8
9	SNF/PED					9
10	ICF	35,205	7,053		42,258	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,050	7,053	6,320	50,423	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.05%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/06/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/06/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 6,320

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	170,025	21,227	7,490	198,742		198,742	1,115	199,857			1
2	Food Purchase		195,933		195,933	(13,031)	182,902	(2,751)	180,151			2
3	Housekeeping	141,501	26,517		168,018		168,018		168,018			3
4	Laundry	62,759	19,107		81,866		81,866		81,866			4
5	Heat and Other Utilities			111,819	111,819		111,819	426	112,245			5
6	Maintenance	55,007	24,913	32,717	112,637		112,637	6,579	119,216			6
7	Other (specify):*			7,392	7,392		7,392		7,392			7
8	**TOTAL General Services**	429,292	287,697	159,418	876,407	(13,031)	863,376	5,369	868,745			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	1,357,483	84,760	276,337	1,718,580		1,718,580	(242,023)	1,476,557			10
10a	Therapy	115,485	7,718	63,896	187,099		187,099	333	187,432			10a
11	Activities	79,704	6,063	1,697	87,464		87,464		87,464			11
12	Social Services	61,198		4,651	65,849		65,849		65,849			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,613,870	98,541	363,381	2,075,792		2,075,792	(241,690)	1,834,102			16
	C. General Administration											
17	Administrative	97,142		126,000	223,142		223,142	(71,652)	151,490			17
18	Directors Fees											18
19	Professional Services			264,763	264,763		264,763	(215,542)	49,221			19
20	Dues, Fees, Subscriptions & Promotions			23,646	23,646		23,646	(3,754)	19,892			20
21	Clerical & General Office Expenses	120,919	18,138	160,106	299,163		299,163	(67,379)	231,784			21
22	Employee Benefits & Payroll Taxes			312,193	312,193	13,031	325,224		325,224			22
23	Inservice Training & Education			1,523	1,523		1,523	1,029	2,552			23
24	Travel and Seminar			5,624	5,624		5,624	412	6,036			24
25	Other Admin. Staff Transportation			2,916	2,916		2,916	2,907	5,823			25
26	Insurance-Prop.Liab.Malpractice			157,258	157,258		157,258	4,374	161,632			26
27	Other (specify):*							40,391	40,391			27
28	**TOTAL General Administration**	218,061	18,138	1,054,029	1,290,228	13,031	1,303,259	(309,214)	994,045			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,261,223	404,376	1,576,828	4,242,427		4,242,427	(545,535)	3,696,892			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER #0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,270	41,270		41,270	108,479	149,749			30
31	Amortization of Pre-Op. & Org.			1,663	1,663		1,663		1,663			31
32	Interest			4,015	4,015		4,015	426,455	430,470			32
33	Real Estate Taxes			133,800	133,800		133,800		133,800			33
34	Rent-Facility & Grounds			575,247	575,247		575,247	(566,582)	8,665			34
35	Rent-Equipment & Vehicles			41,007	41,007		41,007	(5,310)	35,697			35
36	Other (specify):*											36
37	**TOTAL Ownership**			797,002	797,002		797,002	(36,958)	760,044			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		299,044	186,840	485,884		485,884	(25,429)	460,455			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,908	96,908		96,908		96,908			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		299,044	283,748	582,792		582,792	(25,429)	557,363			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,261,223	703,420	2,657,578	5,622,221		5,622,221	(607,922)	5,014,299			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,872)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,751)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(292)	20		17
18	Fines and Penalties	(18,758)	21		18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,199)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(400)	20		28
29	Other-Attach Schedule PAGE 5A	(31,683)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,355)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(526,567)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (526,567)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (607,922)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RIVER PARK HEALTHCARE CENTER

ID# 0042549

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (4,880)	6	1
2	MARKETING SALARY	(26,803)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(31,683)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	1,115	0	0	0	0	0	0	0	0	0	1,115	1
2	Food Purchase	(2,751)	0	0	0	0	0	0	0	0	0	0	(2,751)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	426	0	0	0	0	0	0	0	0	0	426	5
6	Maintenance	(4,880)	11,459	0	0	0	0	0	0	0	0	0	6,579	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,631)	13,000	0	0	0	0	0	0	0	0	0	5,369	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(242,023)	0	0	0	0	0	0	0	0	0	(242,023)	10
10a	Therapy	0	9,030	(8,697)	0	0	0	0	0	0	0	0	333	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(232,993)	(8,697)	0	0	0	0	0	0	0	0	(241,690)	16
	C. General Administration													
17	Administrative	0	(71,652)	0	0	0	0	0	0	0	0	0	(71,652)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(215,542)	0	0	0	0	0	0	0	0	0	(215,542)	19
20	Fees, Subscriptions & Promotions	(6,291)	0	2,537	0	0	0	0	0	0	0	0	(3,754)	20
21	Clerical & General Office Expenses	(45,561)	(106,200)	84,382	0	0	0	0	0	0	0	0	(67,379)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,029	0	0	0	0	0	0	0	0	1,029	23
24	Travel and Seminar	0	0	412	0	0	0	0	0	0	0	0	412	24
25	Other Admin. Staff Transportation	0	0	2,907	0	0	0	0	0	0	0	0	2,907	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,374	0	0	0	0	0	0	0	0	4,374	26
27	Other (specify):*	0	0	40,391	0	0	0	0	0	0	0	0	40,391	27
28	**TOTAL General Administration**	(51,852)	(393,394)	136,032	0	0	0	0	0	0	0	0	(309,214)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,483)	(613,387)	127,335	0	0	0	0	0	0	0	0	(545,535)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,872)	0	130,351	0	0	0	0	0	0	0	0	108,479	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	426,455	0	0	0	0	0	0	0	0	426,455	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(566,582)	0	0	0	0	0	0	0	0	(566,582)	34
35	Rent-Equipment & Vehicles	0	0	(5,310)	0	0	0	0	0	0	0	0	(5,310)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,872)	0	(15,086)	0	0	0	0	0	0	0	0	(36,958)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(25,429)	0	0	0	0	0	0	0	0	(25,429)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(25,429)	0	0	0	0	0	0	0	0	(25,429)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(81,355)	(613,387)	86,820	0	0	0	0	0	0	0	0	(607,922)	45

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY
				RIVER PARK HEALTHCARE CENTER LLC		
					NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 126,000	CAREPLUS MGMT INC		$	$ (126,000)	1
2	V	19	ADMIN. CONSULTANT FEES	210,000	" "			(210,000)	2
3	V	19	DATA PROCESSING FEES	13,200	" "			(13,200)	3
4	V	21	CLERICAL FEES	106,200	" "			(106,200)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	1	DIETARY SALARIES		" "		8,315	8,315	6
7	V	5	ELECTRICITY		" "		426	426	7
8	V	6	REPAIRS		" "		1,011	1,011	8
9	V	6	MAINTENANCE SALARIES		" "		10,448	10,448	9
10	V	10	NURSING	275,000	" "		32,977	(242,023)	10
11	V	10a	THERAPY SALARIES		" "		9,030	9,030	11
12	V	17	ADMIN SALARIES		" "		54,348	54,348	12
13	V	19	PROFESSIONAL FEES		" "		7,658	7,658	13
14	Total			$ 737,600			$ 124,213	$ * (613,387)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 2,537	$ 2,537	15
16	V	21	OFFICE SALARIES/EXPENSES		" "		84,382	84,382	16
17	V	23	SEMINARS		" "		1,029	1,029	17
18	V	24	TRAVEL		" "		412	412	18
19	V	25	TRANSPORTATION		" "		2,907	2,907	19
20	V	26	INSURANCE		" "		4,374	4,374	20
21	V	27	EMPLOYEE BENEFITS		" "		40,391	40,391	21
22	V	30	SL DEPRECIATION		" "		13,744	13,744	22
23	V	32	INTEREST		" "		33,722	33,722	23
24	V	34	OFFICE RENT		" "		8,665	8,665	24
25	V	35	EQUIP RENT/AUTO LEASE	13,337	" "		8,027	(5,310)	25
26	V								26
27	V								27
28	V								28
29	V	10a	THERAPY SERVICES	63,896	CAREPLUS REHABILITATIVE SERVICES		55,199	(8,697)	29
30	V	39	ANCILLARY THERAPY	186,838	" "		161,409	(25,429)	30
31	V								31
32	V								32
33	V								33
34	V	34	RENT	575,247	RIVER PARK HEALTHCARE CENTER LLC			(575,247)	34
35	V	30	SL DEPRECIATION		" "		116,607	116,607	35
36	V	32	INTEREST		" "		392,733	392,733	36
37	V								37
38	V								38
39	Total			$ 839,318			$ 926,138	$ * 86,820	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	32.02	SEE ATTACHED	5.2	8.70	SALARY	16,090	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	32.02	SCHEDULES	5.2	8.70	" "	16,090	17-7	3
4	JAMEE O'BRIEN	REGIONAL DIR.	ADMIN	1.70	" "	5.2	8.70	" "	9,438	17-7	4
5	JOE ZIMMERMAN	CFO	CLERICAL	1.70	" "	5.2	8.70	" "	10,381	21-7	5
6	BARAK BAVER	OFFICE MANAGER	CLERICAL	0.56	" "	5.2	8.70	" "	5,558	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,557		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9 FACILITIES	$ 75,722	$	50,423	$ 8,315	1
2	5	ELECTRICITY	" "	579,760	13 FACILITIES	4,894		50,423	426	2
3	6	REPAIRS	" "	579,760	13 FACILITIES	11,630		50,423	1,011	3
4	6	MAINTENANCE SALARIES	" "	579,760	13 FACILITIES	120,135	120,135	50,423	10,448	4
5	10	NURSING	" "	579,760	13 FACILITIES	379,168	379,168	50,423	32,977	5
6	10a	THERAPY SALARIES	" "	579,760	13 FACILITIES	103,831	100,459	50,423	9,030	6
7	17	ADMIN SALARIES	" "	579,760	13 FACILITIES	624,886		50,423	54,348	7
8	19	PROFESSIONAL FEES	" "	579,760	13 FACILITIES	88,050		50,423	7,658	8
9	20	DUES/LICENSES/WANT ADS	" "	579,760	13 FACILITIES	29,166		50,423	2,537	9
10	21	OFFICE SALARIES/EXPENSES	" "	579,760	13 FACILITIES	970,207	726,859	50,423	84,382	10
11	23	SEMINARS	" "	579,760	13 FACILITIES	11,834		50,423	1,029	11
12	24	TRAVEL	" "	579,760	13 FACILITIES	4,741		50,423	412	12
13	25	TRANSPORTATION	" "	579,760	13 FACILITIES	33,424		50,423	2,907	13
14	26	INSURANCE	" "	579,760	13 FACILITIES	50,288		50,423	4,374	14
15	27	EMPLOYEE BENEFITS	" "	579,760	13 FACILITIES	464,414		50,423	40,391	15
16	30	SL DEPRECIATION	" "	579,760	13 FACILITIES	158,032		50,423	13,744	16
17	32	INTEREST	" "	579,760	13 FACILITIES	387,734		50,423	33,722	17
18	34	OFFICE RENT	" "	579,760	13 FACILITIES	99,626		50,423	8,665	18
19	35	EQUIP RENT/AUTO LEASE	" "	579,760	13 FACILITIES	92,291		50,423	8,027	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,710,073	$ 1,326,621		$ 324,403	25

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC						$	$			$	1
2	CIB BANK		X	CAPITAL IMPROVEMENTS	$5,687.22	02/01	270,000	179,223	02/06	PRIME+	16,863	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	02/01	1,350	855			270	3
4	CIB BANK		X	MORTGAGE	$42,224.00	12/98	5,100,000	4,602,771	12/04	7.7500	367,645	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN	09/97	46,071	12,327			7,955	5
	Working Capital											
6	INSURANCE FINANCING		X	INSUR. FINANCE							4,015	6
7	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC										33,722	7
8												8
9	TOTAL Facility Related				$47,911.22		$ 5,417,421	$ 4,795,176			$ 430,470	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,417,421	$ 4,795,176			$ 430,470	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 124,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 128,360	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,160	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 129,640	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 133,800	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	120,896	8
	1998	120,575	9
	1999	120,444	10
	2000	122,973	11
	2001	128,360	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible] Office of Health Finance at (217) 782-1600.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER PARK HEALTHCARE CENTER COUNTY ROCK ISLAND

FACILITY IDPH LICENSE NUMBER 0042549

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-341-79-00	NURSING HOME	$ 1,131.40	$ 1,131.40
2.	10-341-78-00	NURSING HOME	$ 127,228.32	$ 127,228.32
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 128,359.72	$ 128,359.72

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,494 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 4 + BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,312
2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 1,663
4. Dates Incurred: 5/97

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	RELATED PARTY:RIVER PARK HEALTHCARE CENTER LLC			$	1
2	NURSING HOME:	5.16 ACRES	1997	420,000	2
3	TOTALS			$ 420,000	3

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: RIVER PARK HEALTHCARE CENTER LLC:				$	$		$	$	$	4
5	177		1997	1975	3,596,265	92,208	39	92,208		487,977	5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING,WALLCOVER,WINDOW TREATMENTS,DOORS			1997	66,202	1,698	39	1,698		9,573	9
10	WINDOWS			1998	2,278	58	39	58		259	10
11	WALK-IN FREEZER COMPRESSOR			2000	2,097	76	27.5	76		219	11
12	ELECTRICAL WORK			2001	1,854	67	27.5	67		115	12
13	NEW GREASE TRAP & CHANGEOUT WATER HEATER			2002	10,887	27	27.5	27		27	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					102		102			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,679,583	$ 94,236		$ 94,236	$	$ 498,170	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 188,174	$ 26,225	$ 15,064	$ (11,161)	8-15 YRS	$ 56,291	71
72	Current Year Purchases	25,768	10,858	1,057	(9,801)	8-15 YRS	1,057	72
73	Fully Depreciated Assets							73
74	** RELATED PARTY - SL DEPN: CAREPLUS MGMT, 13,642 / RIVER PARK LLC, 22,500		36,142	36,142				74
75	TOTALS	$ 213,942	$ 73,225	$ 52,263	$ (20,962)		$ 57,348	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY VAN		2001	$ 13,000	$ 4,160	$ 3,250	$ (910)	4 YRS	$ 4,875	76
77										77
78										78
79										79
80	TOTALS			$ 13,000	$ 4,160	$ 3,250	$ (910)		$ 4,875	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,326,525	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 171,621	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,749	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,872)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 560,393	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A -- RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 41,007 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 80,229	$		$ 80,229	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,224			6,224	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			91,481			91,481	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				161,352		161,352	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2 / 39-3				8,906	103,755		112,661	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					33,937		33,937	13
14	TOTAL			$		$ 186,840	$ 299,044		$ 485,884	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER **#** 0042549 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (40,578)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	1,703,118		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,345,000		5
6	Prepaid Insurance	83,309		6
7	Other Prepaid Expenses	692		7
8	Accounts Receivable (owners or related parties)	67,810		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,159,351	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	10,887		15
16	Equipment, at Historical Cost	226,942		16
17	Accumulated Depreciation (book methods)	(147,451)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 90,378	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,249,729	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 698,460	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,945		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,275		31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,640		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 937,320	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO LLC	117,625		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 117,625	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,054,945	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,194,784	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,249,729	$	48

***(See instructions.)**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,775,211	1
2	Restatements (describe):		2
3	2001 IL REPLACEMENT TAX	(911)	3
4	POST-CLOSING ALLOWANCE FOR BAD DEBTS	(50,000)	4
5	ROUNDING	7	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,724,307	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	470,477	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 470,477	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,194,784	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,987,014	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,987,014	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	20,515	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 20,515	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	94,424	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 94,424	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,101,953	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	876,407	31
32	Health Care	2,075,792	32
33	General Administration	1,290,228	33
	B. Capital Expense		
34	Ownership	797,002	34
	C. Ancillary Expense		
35	Special Cost Centers	485,884	35
36	Provider Participation Fee	96,908	36
	D. Other Expenses (specify):		
37	OUT OF PERIOD EXPENSES	8,255	37
38	LEGAL SETTLEMENT	1,000	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,631,476	40
41	**Income before Income Taxes (line 30 minus line 40)****	470,477	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 470,477	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,837	4,305	$ 103,176	$ 23.97	1
2	Assistant Director of Nursing	319	319	6,218	19.49	2
3	Registered Nurses	6,447	6,717	127,392	18.97	3
4	Licensed Practical Nurses	30,525	32,401	491,773	15.18	4
5	Nurse Aides & Orderlies	66,259	67,433	606,037	8.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,545	12,366	115,485	9.34	8
9	Activity Director	1,999	2,177	23,902	10.98	9
10	Activity Assistants	5,821	6,476	55,802	8.62	10
11	Social Service Workers	3,777	4,058	61,198	15.08	11
12	Dietician					12
13	Food Service Supervisor	1,999	2,105	30,243	14.37	13
14	Head Cook	8,403	8,876	69,842	7.87	14
15	Cook Helpers/Assistants	10,559	11,000	69,940	6.36	15
16	Dishwashers					16
17	Maintenance Workers	4,773	4,969	55,007	11.07	17
18	Housekeepers	17,488	18,506	141,501	7.65	18
19	Laundry	8,181	8,612	62,759	7.29	19
20	Administrator	1,992	2,168	63,263	29.18	20
21	Assistant Administrator	2,040	2,213	33,879	15.31	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,933	7,517	94,116	12.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,238	22,887	10.23	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,974	2,046	26,803	13.10	33
34	TOTAL (lines 1 - 33)	196,955	206,502	$ 2,261,223 *	$ 10.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	16,800	9-3	36
37	Medical Records Consultant	N	75,000	10-3	37
38	Nurse Consultant	T	150,000	10-3	38
39	Pharmacist Consultant	H	1,199	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,697	11-3	44
45	Social Service Consultant	E	4,651	12-3	45
46	Other(specify)	S			46
47	PSYCHIATRIC		50,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 320,947		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRIS WELCH	ADMIN	0	$ 63,263
TAMARA STONEBERGER	ASST ADMIN	0	33,879
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 97,142

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 126,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 126,000

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 13,200
CAREPLUS MGMT	ADMIN CONSULT	210,000
AMERICAN DATA	DATA PROC	2,747
RICHARD PEELO	M/C COST REPORT	3,750
KBKB	ACCT	25,950
MEYER MAGENCE	LEGAL	5,582
PERSONNEL PLANNERS	UNEMPL CONSULT	1,620
NATIONAL DATACARE	DATA PROC	1,308
SACHNOFF & WEAVER	LEGAL	606
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 264,763

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,626
Unemployment Compensation Insurance	27,796
FICA Taxes	169,583
Employee Health Insurance	48,852
Employee Meals	13,031
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,548
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	1,788
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,224

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,390
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	5,599
TRUST/FRANCHISE/CONTRIB/ETC	692
LICENSES & PERMITS	1,102
DUES & SUBSCRIPTIONS	9,663
MGMT CO ALLOCATION	2,537
TRUST/FRANCHISE/CONTRIB/ETC	(692)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,199)
Yellow page advertising	(400)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,892

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL & LODGING	5,624
MGMT CO ALLOCATION	412
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,036

**See instructions.

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	2001	$ 2,062	3	$	$	$ 344	$ 687	$ 687	$ 344	$	$	$
2	PAINT/DECORATING	2002	6,681	3				1,114	2,227	2,227	1,113		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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16													
17													
18													
19													
20	TOTALS		$ 8,743		$	$	$ 344	$ 1,801	$ 2,914	$ 2,571	$ 1,113	$	$

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER # 0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $9,558**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,908**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,031** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: RIVER PARK HEALTHCARE CENTER #0042549 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		290	
			0	7,490
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,067	
	ELECTRICITY		73,988	
	WATER		21,924	
	CABLE TV - LOBBY		840	
			0	111,819
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		0	
	PAINTING & DECORATING		6,681	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		302	
	EQUIPMENT MAINTENANCE & REPAIR		6,055	
	ELEVATOR MAINTENANCE & REPAIR		10,700	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,696	
	FIRE SERVICE		7,283	
			0	
			0	
			0	32,717
7	**OTHER**			
	SCAVENGER		7,392	
	SECURITY SERVICE		0	7,392
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	16,800	16,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		138	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	75,000	
	PHARMACY CONSULTANT	XVIII B 39-2	1,199	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 47-2	50,000	
	RN CONSULTANT	XVIII B 38-2	150,000	
			0	
			0	276,337
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		8,411	
	SPEECH THERAPY SERVICES		661	
	OCCUPATIONAL THERAPY SERVICES		8,694	
	THERAPY CONTRACT SERVICES		31,730	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	63,896
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,697	
			0	1,697
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,651	
			0	4,651
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number RIVER PARK HEALTHCARE CENTER **#0042549** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	126,000	126,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,255	
	ADMINISTRATIVE CONSULTANTS	XIX C	210,000	
	PROFESSIONAL FEES	XIX C	37,508	
			0	264,763
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,199	
	EMPLOYEE WANT ADS	XIX F	6,390	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,663	
	LICENSES & PERMITS	XIX F	1,302	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	400	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	292	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	400	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,646
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		555	
	EQUIPMENT REPAIR & MAINTENANCE		12,535	
	OUTSIDE CLERICAL SERVICES		106,200	
	PENALTIES / OVERDRAFT CHARGES	VI 18	18,758	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,117	
	MESSENGER SERVICE		1,941	
			0	160,106

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	169,583	
	UNEMPLOYMENT COMPENSATION	XIX D	27,796	
	WORKERS COMPENSATION INSURANC	XIX D	61,626	
	HOSPITALIZATION INSURANCE	XIX D	48,852	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,548	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,788	
	CHICAGO HEAD TAX	XIX D	0	312,193
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,523	1,523
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	5,624	
			0	
			0	5,624
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,916	2,916
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		157,258	157,258
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,576,828

RIVER PARK HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	195,933
LESS SALES TAX	(2,751)
NET FOOD	193,182
TOTAL PATIENT CENSUS	50,423
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	151269
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	151269
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	162219
NET FOOD	193182
DIVIDE TOTAL MEALS/YEAR	162219
COST PER MEAL	1.19
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	13031

RIVER PARK HEALTHCARE CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									5,908,674	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	2,075,792	312,193	399,866	81,866	394,675	978,035	96,908	797,002		2,261,223
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	17,086		8,525			15,396		(41,007)		
CABLE TV			(840)			840				
CONTRACT NURSING										
INTEREST INCOME							(3)	(94,421)		
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(126,000)		126,000		
O2 INCOME							(20,515)			
BAD DEBTS						0	0			
DISCOUNTS LOST							0			
ANCILLARIES	485,884							0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	(84,085)	0	0	0	0	84,085	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(69,085)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	2,494,677	312,193	407,551	81,866	394,675	952,356	7,305	787,574	5,438,197	2,261,223
PER FINANCIAL STATEMENTS	2,494,677	312,193	407,551	81,866	394,675	952,356	7,305	787,574	470,477	2,261,222
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									470,477	

RIVER PARK HEALTHCARE CENTER - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		64,605			64,605			0	64782		
CENSUS DAYS		50,423			52,226			(1,803)	54652		
OCCUPANCY %		78.05%			80.84%				84.36%		
SALARIES											
TOTAL General Services	8-1	429,292	8.56%	8.51	416727	8.93%	7.98	12,565	384888	8.96%	7.04
Social Services	12-1	61,198	1.22%	1.21	70553	1.51%	1.35	(9,355)	58330	1.36%	1.07
TOTAL Health Care and Programs	16-1	1,613,870	32.19%	32.01	1554099	33.29%	29.76	59,771	1472742	34.27%	26.95
Clerical & General Office Expenses	21-1	120,919	2.41%	2.40	107379	2.30%	2.06	13,540	94062	2.19%	1.72
TOTAL General Administration	28-1	218,061	4.35%	4.32	206565	4.43%	3.96	11,496	192591	4.48%	3.52
TOTAL Operation Expense	29-1	2,261,223	45.10%	44.85	2177391	46.65%	41.69	83,832	2050221	47.70%	37.51
ADJUSTED TOTALS											
Food	2-8	180,151	3.59%	3.57	200073	4.29%	3.83	(19,922)	190943	4.44%	3.49
Heat and Other Utilities	5-8	112,245	2.24%	2.23	112797	2.42%	2.16	(552)	118296	2.75%	2.16
Maintenance	6-8	119,216	2.38%	2.36	112056	2.40%	2.15	7,160	113810	2.65%	2.08
TOTAL General Services	8-8	868,745	17.33%	17.23	878941	18.83%	16.83	(10,196)	832453	19.37%	15.23
Administrative	17-8	151,490	3.02%	3.00	200348	4.29%	3.84	(48,858)	201027	4.68%	3.68
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
Professional Services	19-8	49,221	0.98%	0.98	45643	0.98%	0.87	3,578	46282	1.08%	0.85
Fees, Subscriptions, Promotions	20-8	19,892	0.40%	0.39	23115	0.50%	0.44	(3,223)	12678	0.29%	0.23
License Fee-IDPA	Pg21	200	0.00%	0.00	0	0.00%	0.00	200	0	0.00%	0.00
License Fee-Other	Pg21	1,102	0.02%	0.02	440	0.01%	0.01	662	550	0.01%	0.01
Clerical & General Office Expenses	21-8	231,784	4.62%	4.60	198795	4.26%	3.81	32,989	166872	3.88%	3.05
Employee Benefits & Payroll Taxes	22-8	325,224	6.49%	6.45	295721	6.34%	5.66	29,503	279284	6.50%	5.11
Payroll Taxes	Pg21	197,379	3.94%	3.91	194455	4.17%	3.72	2,924	177993	4.14%	3.26
W/C Insurance	Pg21	61,626	1.23%	1.22	52649	1.13%	1.01	8,977	65313	1.52%	1.20
Health Insurance	Pg21	48,852	0.97%	0.97	26317	0.56%	0.50	22,535	18425	0.43%	0.34
Inservice Training & Education	23-8	2,552	0.05%	0.05	1709	0.04%	0.03	843	2114	0.05%	0.04
Travel and Seminar	24-8	6,036	0.12%	0.12	6010	0.13%	0.12	26	7089	0.16%	0.13
Other Admin. Staff Transportation	25-8	5,823	0.12%	0.12	6194	0.13%	0.12	(371)	13163	0.31%	0.24
Insurance-Prop.Liab.Malpractice	26-8	161,632	3.22%	3.21	145391	3.11%	2.78	16,241	89471	2.08%	1.64
Other (specify):*	27-8	40,391	0.81%	0.80	39976	0.86%	0.77	415	27640	0.64%	0.51
TOTAL General Administration	28-8	994,045	19.82%	19.71	962902	20.63%	18.44	31,143	845620	19.67%	15.47
TOTAL Operation Expense	29-8	3,696,892	73.73%	73.32	3621321	77.58%	69.34	75,571	3326376	77.39%	60.86
Real Estate Taxes	33-3	133,800	2.67%	2.65	125523	2.69%	2.40	8,277	120314	2.80%	2.20
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,014,299	100.00%	**99.44**	4667709	100.00%	**89.38**	346,590	4297971	100.00%	**78.64**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1630672.6	32.52%	**32.34**	1630774	34.94%	**31.23**	(101)	1477454	34.38%	**27.03**

RIVER PARK HEALTHCARE CENTER - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1801 from Page 22 and -6681 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-426455 RELATED PARTY 426455
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-130351 RELATED PARTY 130351
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4. N/A-RELATED PARTY
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.